

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07711 355

1. PLACE OF DEATH:

County Worcester
 City or town Rural - Berlin R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 27 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Rural - Berlin R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Berlin R.F.D. - St Martins
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Laura Elma Adkins

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William E. Adkins
 6. (c) If alive, give age 61 years
 7. Birth date of deceased (mo., day, yr.) Feb. 15, 1890
 8. AGE: Years 58 Months 4 Days 21 If less than one day
 hrs. min.

9. Birthplace New Castle Co. Delaware
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name William Hall13. Birthplace Delaware14. Maiden name Mary McKensy15. Birthplace Delaware16. Informant MR. WILLIAM E. ADKINSAddress BERLIN, MD. R.F.D.17. Burial Date thereof 7/8/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Evergreen Cem.Location Berlin, Md. R.F.D.18. Funeral director Ans A. SurbazerAddress Berlin Md.19. 7-7- 48 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 - 1948 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on July 6 - 1948

Immediate cause of death

DURATION

Due to Cerebral Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. R. Low MDAddress Berlin Md. Date signed 7-7-48

RECEIVED

JUL 12 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07712

Reg. Dist. No. 855

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 21 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Frank Whayland Baysinger

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Carmel Baysinger

7. Birth date of

deceased (mo., day, yr.)

June 17, 1870

8. AGE:

Years

Months

Days

If less than one day

78028

hrs.

min.

9. Birthplace

Whitchley Ohio
(Town, county, and state)

10. Usual occupation

Concrete mfg (Retired)

11. Industry or business

FATHER
MOTHER

12. Name

James Baysinger

13. Birthplace

Penn.

14. Maiden name

Mary Johnston

15. Birthplace

Cumberland Md.

16. Informant

Mr. Wm Baysinger

Address

Salisbury Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

7/18/48
(month) (day) (year)

Cemetery or crematory

Bushington

Location

Berlin Md.

18. Funeral director

Anna A. Burbage

Address

Berlin Md

19.

7-18
(Date rec'd by registrar)

19

48Helen F. Hayward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 July 19 48, at 430 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb19 47, to 11 July 19 48and that I last saw h. alive on 10 July 19 48

Immediate cause of death

Chronic Degenerative Myocarditis
C. Hypostatic Pneumonia
Chronic Hypertension &
deforming arthritis

DURATION

2 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harmonie Raldis M. D. or otherAddress 5 Bay St. Berlin Md Date signed 17 July 48

RECEIVED

JUL 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH: Worcester
 County.....
 City or town..... Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 30yrs
 Hospital, institution, or street address where death occurred:
 X
 X
 How long in hospital or institution?..... X

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland..... County..... Worcester
 City or town..... Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Ocean City Blvd.
 (If rural, give LOCATION) X
 2.(a) If veteran, name war.....

3. (a) FULL NAME JOSHUA JACKSON BUNTING

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Viola Mae Bunting
 6. (c) If alive, give age 87 years
 7. Birth date of deceased (mo., day, yr.) December 10, 1859
 8. AGE: Years 88 Months 7 Days 10 If less than one day hrs. min.

9. Birthplace Bishopville, Md.
 (Town, county, and state)
 10. Usual occupation Farmer

11. Industry or business
 12. Name Elijah Bunting Md.
 13. Birthplace Amie Campbell Md.

14. Maiden name
 15. Birthplace

16. Informant Mrs. Frank Magee
 Address Berlin, Md.

17. Burial July 23, 1948
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory I. O. O. F.
 Location Bishopville, Md.

18. Funeral director M. Pasha Watson
 Address Salisbury, Del.

19. 7-23-48 Helen G. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1948, at 7:30a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1947 to 21 July 1948
 and that I last saw him alive on 21 July 1948

Immediate cause of death Coronary Sclerosis
 (Marsenne Central
 heartmortality)
 Due to Renal artery
 atherosclerosis
 Due to
 Other conditions Hypertensive Pneumonia
 (Include pregnancy within 8 months of death)
 Major findings of operations
 Date of op.

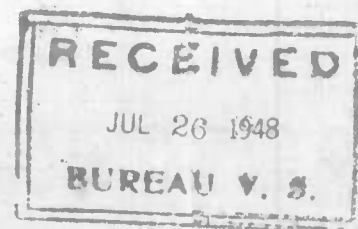
Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE H. B. Berlin Md
 Address 5 Bay St. Berlin Md Date signed 22 July 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH

County WorcesterCity or town Stachton, Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Stachton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret Frances Collins

3. (b) Social Security Number

none

4. Sex

Female

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) May 20 - 1948

6. (c) If alive, give age _____ years

8. AGE: Years _____ Months 2 Days 3 If less than one day _____ hrs. _____ min.9. Birthplace Stachton, Worcester, Md
(Town, county, and state)

16. Usual occupation:

11. Industry or business

12. Name Elwood Collins13. Birthplace Maryland14. Maiden name Ellen Douglas15. Birthplace Maryland16. Informant Elwood CollinsAddress Stachton, Md Rural #17. (Burial, cremation, or removal, Which?) Burial Date thereof July 23/48
(month) (day) (year)Cemetery or crematory MethodistLocation Stachton, Md18. Funeral director Walter E. ThomasAddress Brook Hill Md19. (Date rec'd by registrar) 7/24 1948 Mary M. Taylor Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 23 1948 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 1948 to _____ 1948and that I last saw him/her alive on ended 7-23 1948

Immediate cause of death _____ DURATION

Pneumonia, Bronchial 1000?

Due to _____

Due to _____

Other conditions unimportant

(Include pregnancy within 8 months of death)

Major findings of operations No

Date of op. _____

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____Where did injury occur? No (City or town) _____ (County) _____ (State) _____Injured at home, farm, industry, public place (where?) No

Means of injury _____ Injured at work? _____

23. SIGNATURE Isaacsche MD M. D. or otherAddress Sweeten Md Date signed 7/23/48

RECEIVED

JUL 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

99

077715

Reg. Dist. No.

855

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. Williams St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jennie E. Dilworth

3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife John Dilworth7. Birth date of deceased (mo., day, yr.) Feb. 20, 1861

6. (c) If alive, give age years

8. AGE: Years 87 Months 2 Days 12 If less than one day hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Samuel Cropper13. Birthplace Maryland14. Maiden name Letitia Davis15. Birthplace Maryland16. Informant Mrs. Letitia CropperAddress Berlin MD17. Burial Date thereof 7/4/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Buchan's LaneLocation Berlin MD18. Funeral director Anna A. BurboysAddress Berlin MD19. 7-3- Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 48 at 3 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 46 to July 2 19 48and that I last saw her alive on July 2 19 48Immediate cause of death Chronic aortic

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford E. Schutt M. D. or otherAddress Berlin MD Date signed 7-3-48

RECEIVED

JUL 6 1948

BUREAU V. 8

RECEIVED

JUL 6 1948

BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

85

07716

Reg. Dist. No. 351

1. PLACE OF DEATH

County Worcester
 City or town Snow Hill (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County Norfolk
 City or town Portsmouth
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1306 Summit Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Lewis Gaines
 4. Sex Male 5. Color or race aa 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 4 - 1908

8. AGE: Years 40 Months 2 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Shenandoah, Bedford N. C.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Clay Mining Factory

12. Name David B. Gaines

13. Birthplace Concord N. C.

14. Maiden name Frances Calines

15. Birthplace Unknown

16. Informant Leila Smith

Address 1306 Summit Ave Portsmouth Va

17. Burial Reinterment Date thereof July 7/48
 (Burial, cremation, or reinterment) (month) (day) (year)

Cemetery or crematory Lincoln

Location Portsmouth Virginia

18. Funeral director Elmer B. Davis

Address Snow Hill, Md

19. 7/31 19 48 LeRoy Smith
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

226-14-6601

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 July 19 48 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
deceased 19 48 to 7-1- 19 48
 and that I last saw him dead 7-1-48 19 48

Immediate cause of death _____ DURATION years

Epilepsy

Due to _____

Due to _____

Other conditions Not important

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____

Where did injury occur? No (City or town) (County) (State)

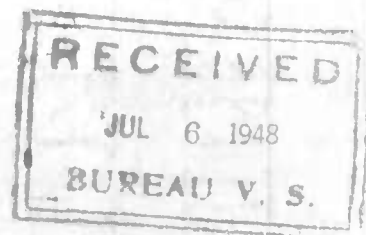
Injured at home, farm, industry, public place (where?) No

Means of injury No Injured at work?

Signature Sevaerche, M.D. DME

Address Snow Hill Md M. D. or other 7/21/48

Date signed _____



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

077717

355

1. PLACE OF DEATH:

County Worcester
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 70 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Worcester
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles Henry Holcomb

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower
 6. (b) Name of husband or wife Minnie R. Holcomb
 7. Birth date of deceased (mo., day, yr.) Feb. 5, 1875
 6. (c) If alive, give age _____ years
 8. AGE: Years 73 Months 5 Days 19 It less than one day _____ hrs. _____ min.

9. Birthplace Berlin W.C. md
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business

FATHER 12. Name Stringer Holcomb
 13. Birthplace md
 MOTHER 14. Maiden name Gray
 15. Birthplace md

16. Informant Mr. Vincent Holcomb
 Address Berlin md

17. Burial Date thereof 7/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Evergreen
 Location Berlin md

18. Funeral director Anna A. Burbo
 Address Berlin md

19. 7-25 19 48 Helen J. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 24 19 48 5 A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 1 19 47 to JULY 24 19 48
 and that I last saw h. IM alive on JULY 23 19 48

Immediate cause of death CHRONIC ENDOCARDITIS
 DURATION
 Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Clifford E. Schott
CLIFFORD E. SCHOTT M. D. or other
BERLIN MD Date signed

RECEIVED

JUL 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

Reg. Dist. No.

07718
353

1. PLACE OF DEATH:

County Worcester
City or town Shawell
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Hudson4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widower6. (b) Name of husband or wife Elmer Hudson7. Birth date of deceased (mo., day, yr.) Apr. 7, 18748. AGE: Years 74 Months 1 Days 24 It less than one day hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farming

11. Industry or business

12. Name John Henry Hudson13. Birthplace md.14. Maiden name Unknown

15. Birthplace

16. Informant Floy BuntingAddress Shawell17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1948
(month) (day) (year)Cemetery or crematory Ebenezer Church yardLocation near Seabrook, Del.18. Funeral director Henry H. WatsonAddress Pocomoke City, Md.19. 7/3 48 Mrs. Ray Perry

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County WorcesterCity or town Bishop R.D.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 48 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 47 to 1 July 19 48and that I last saw him alive on 1 July 19 48

Immediate cause of death

Carcinoma of the headof the parotid glandDue to metastasis of theliver

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

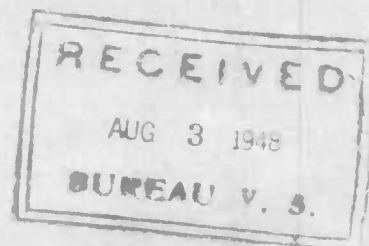
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Watson M. D. or otherAddress 5 Bay St. Seabrook, Md. Date signed 2 July 48



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1702
0007719
357

Reg. Dist. No.

1. PLACE OF DEATH: Moneta
County.....
City or town..... Snow Hill Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Virginia County..... Bedford
City or town..... Moneta Rural #43
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war..... World War II

3. (a) FULL NAME Stewart B. Lloyd

3. (b) Social Security Number
225-12-9172

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 15 - 1914 6. (c) If alive, give age..... years

8. AGE: Years 33 Months 8 Days 3 hrs. min.

9. Birthplace Moneta Bedford, Virginia
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Thomas J. Lloyd

12. Name.....

13. Birthplace Virginia

14. Maiden name Lillie B. Lewis

15. Birthplace Virginia

16. Informant M. Harry E. Lloyd

Address 3207 Woodlawn Ave Roanoke Va

17. Burial Date thereof July 21/48
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Lloyd Cemetery

Location Moneta, Virginia

18. Funeral director L. E. E. Dymally

Address Snow Hill, Md

19. 7/19/48 19. 48 LeRoy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 July 19. 48 10 32 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 July 19. 48 18 July 19. 48

and that I last saw him/her on 18 July 19. 48

Immediate cause of death.....

Fracture Base of Skull DURATION 18 min.

Due to.....

Due to.....

Other conditions Multiple contusions and lacerations

(Include pregnancy within 8 months of death)

Major findings of operations.....

none Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 18 July 1948

Where did injury occur on Snow Hill road (City or town) (County) (State)

Injured at home, farm, industry, public place (where) Pub. Hwy.

Means of injury Motorcycle Accident

23. SIGNATURE J. S. Waesche M.D. DME M. D. or other

Address Snow Hill Md Date signed 7/19/48

RECEIVED

JUL 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07721 350

1. PLACE OF DEATH:

County..... Worcester
 City or town..... Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
601 Laurel Street
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Worcester
 City or town..... Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 601 Laurel Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

LAURA MARSHALL

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... John Marshall
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... December 19, 1876
 8. AGE: Years..... 71 Months..... 7 Days..... 12 If less than one day..... hrs. min.

9. Birthplace..... Stockton-Worcester-Maryland
 (Town, county, and state)
Housewife

10. Usual occupation.....

11. Industry or business.....

12. Name..... Jake Collins

13. Birthplace..... Welbourne-Maryland

14. Maiden name..... Hester Collins

15. Birthplace..... Welbourne-Maryland

16. Informant..... Greather Paschal

Address..... Detroit, Michigan

17. Burial..... Burial Date thereof..... August 3, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Paul's Cemetery

Location..... Pocomoke City

18. Funeral director..... H. Harvey Bradshaw

Address..... Crisfield, Maryland

19. Aug. 3, 1948 Anne E. White

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 31 19. 48 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 42 to July 30 19. 48
 and that I last saw him alive on July 30 19. 48

Immediate cause of death..... DURATION.....

Pulmonary edema week

Due to.....

Cardio vascular disease years

Due to.....

Other conditions.....

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Pocomoke City Md M. D. 8/1/48

Address..... Date signed.....

RECEIVED

AUG 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester
 City or town Berlin md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Worcester
 City or town Berlin md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Obee Guillen

3. (b) Social Security Number

no

4. Sex

male

5. Color or race

a.a

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ella Guillen

7. Birth date of deceased (mo., day, yr.)

yes
about 1874

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

74

hrs. min.

9. Birthplace

Berlin md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Same as above

FATHER

12. Name

unknown

13. Birthplace

unknown

MOTHER

14. Maiden name

Mary Kelly

15. Birthplace

Berlin md

16. Informant

Ella Guillen

Address

Berlin md

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Bureau

Location

Berlin md

18. Funeral director

James P. Stewart

Address

Dahabury md

19.

(Date rec'd by registrar)

19

48

Helen S. Hayward

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 12 1948 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1948 to July 12 1948and that I last saw him alive on July 10 1948

Immediate cause of death

Cancer of Mouth

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(city or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clifford E. Schell

M. D. or other

Address

Berlin md

Date signed

RECEIVED

JUL 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 462 0738P 351

1. PLACE OF DEATH

County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war 70

3. (a) FULL NAME

John L. Riley M.D.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Dorothy E. Riley

7. Birth date of deceased (mo., day, yr.)

Feb. 18 - 1875

6. (c) If alive, give age

63 years

8. AGE:

Years	Months	Days	If less than one day
73	5	6	hrs. min.

9. Birthplace

Snow Hill, Worcester, Md.
(Town, county, and state)

10. Usual occupation

Medical Doctor

11. Industry or business

William L. Riley

12. Name

Maryland

13. Birthplace

Crown Point, Md.

14. Maiden name

Maryland

15. Birthplace

Maryland

16. Informant

Mrs. Dorothy E. Riley

Address

Snow Hill, Md.

17. (Burial, cremation, or removal) Which?

Burial Date thereof July 27/48
(month) (day) (year)

Cemetery or crematory

Presbyterian

Location

Snow Hill, Md.

18. Funeral director

Wm. E. Dymms

Address

Snow Hill, Md.

19.

7/27/48 1948 LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 24 1948 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1948 to July 24 1948

and that I last saw him alive on July 23 1948

Immediate cause of death

Cancer of sigmoid

DURATION

3 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Cancer of sigmoid

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Paul Riley M.D. or other

Address: Snow Hill, Md. Date signed: 7/26/48



RECEIVED

JUL 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

351724

1. PLACE OF DEATH: *Worcester*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *77 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME *Sallie M. Truitt*

3. (b) Social Security Number

none

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Charles F. Truitt*

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) *April 6 - 1871*

8. AGE: Years *77* Months *3* Days *15* If less than one day..... hrs. min.

9. Birthplace *Snow Hill Worcester Md*
 (Town, county, and state)

10. Usual occupation *House wife*

11. Industry or business *Own home*

12. Name *Serv. Griner*

13. Birthplace *Maryland*

14. Maiden name *Rachel Richardson*

15. Birthplace *Maryland*

16. Informant *Mrs. Julia Hilbert*

Address *140 Chesapeake Rd. Fairview, Md.*

17. *Burial* Date thereof *July 24/48*
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory *Bates Methodist*

Location *Snow Hill Md*

18. Funeral director *Elmer C. Dumas*

Address *Snow Hill Md*

19. *7/24/48* 19. *48* *R. D. Smith*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *July 21*..... 19. *48* at *9:35* PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July* 19. *46* to *July 21* 19. *48* and that I last saw him alive on *July 20* 19. *48*

Immediate cause of death *cachexia + anemia* DURATION *2 mos*

Due to *5 Carcinoma of Right Breast* *5 yrs*

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

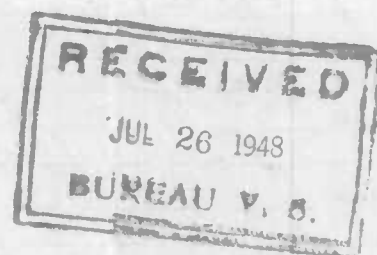
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....
 M. D. or other

Address.....
 Date signed *7.22.48*



PLACE OF DEATH JUL 21 1948

County Worcester

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 355

Village or City Ocean City (No. (YOUNGHAN) St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.) ☒

2 FULL NAME John Younghouse

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) M

16 DATE OF DEATH July 18th, 1948
(Month) July (Day) 18 (Year) 48

6 DATE OF BIRTH WIFE - MARIE ALICE YOUNGHAN
Mar 23, 1896
(Month) Mar (Day) 23 (Year) 1896

I HEREBY CERTIFY, That I attended the deceased and
July 18, 1948,
that I last saw him deceased 7/18, 1948,
and that death occurred on the date stated above, at m.

7 AGE 52 yrs. 3 mos. 26 ds. or min. ?
If LESS than 1 day hrs. min.

The CAUSE OF DEATH * was as follows:

8 OCCUPATION
(a) Trade, profession or particular kind of work Iron worker
(b) General nature of industry, business, or establishment in which employed or (employee) Sanded floors

Coronary disease
(Duration) 1 yrs. 1 mos. 1 ds.

9 BIRTHPLACE (State or country) Balto. Md

Contributory Secondary Hypertension
(Duration) 1 yrs. 1 mos. 1 ds.

10 NAME OF FATHER Rudolph Younghouse

(Signed) N. E. Sartorius
7/18, 1948 (Address) Baltimore City, Md

11 BIRTHPLACE OF FATHER (State or country) Germany

*State the Disease Causing Death, or, In death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

12 MAIDEN NAME OF MOTHER Katherine (D.K.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients & Recent Residents)

13 BIRTHPLACE OF MOTHER (State or country) Germany

At place of death yrs. mos. ds. In the State yrs. mos. ds.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted, if not at place of death?
Former or usual residence.

(Informant) Margie A. Younghouse
2916 Sylvan Baltimore, Md
(Address)

19 PLACE OF BURIAL OR REMOVAL Baltimore Md. DATE OF BURIAL 7/23 1948

15 Filed 7-20 1948 Helen J. Hayward
Registrar

20 UNDERTAKER RUCK'S FUN. HOME
ANNIE A. RUCK Baltimore Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. E.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 21 1918
BUREAU V. S.